Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

B.P.J. by her next friend and mother, HEATHER JACKSON, *Plaintiff*, v. WEST VIRGINIA STATE BOARD OF EDUCATION, HARRISON COUNTY BOARD OF EDUCATION, WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION, W. CLAYTON BURCH in his official capacity as State Superintendent, DORA STUTLER in her official capacity as Harrison County Superintendent, and THE STATE OF WEST VIRGINIA, *Defendants*, and LAINEY ARMISTEAD, *Defendant-Intervenor*.	Civil Action No. 2:21-cv-00316 Hon. Joseph R. Goodwin

REBUTTAL EXPERT REPORT AND DECLARATION OF ARON JANSSEN, M.D.

I, Aron Janssen, M.D., hereby declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I submit this expert declaration based on my personal knowledge.

2. The purpose of this declaration is to respond to the expert reports of Dr. Stephen Levine, MD and Dr. Stephen Cantor, Ph.D., submitted by Defendants in this case, which misrepresent current standards of care for treating gender dysphoria in children and adolescents, the practices commonly known as gender-affirming care, and the scientific data supporting those practices.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation in the body of this declaration.

4. In preparing this declaration, I reviewed: the Complaint in this action, the expert reports of Dr. Joshua D. Safer, M.D., and Dr. Deanna Adkins, M.D., submitted by Plaintiff, and the expert reports of Dr. Levine and Dr. Cantor submitted by Defendants. I also relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields, and my clinical experience treating children, adolescents, and adults with gender dysphoria. A true and accurate copy of my curriculum vitae is attached hereto as Exhibit A. It documents my education, training, research, and years of experience in this field and includes a list of my publications from the last 10 years, which I also rely upon to support my opinions.

5. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

BACKGROUND QUALIFICATIONS

6. I am the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health at the Ann and Robert H. Lurie Children's Hospital of Chicago ("Children's Hospital"), where I also serve as Clinical Associate Professor of Child and Adolescent Psychiatry and Medical Director for Outpatient Psychiatric Services.

7. I previously served as Co-Director of the New York University Pediatric Consultation Liaison Service for the New York University Department of Child and Adolescent Psychiatry. I also was the Founder and Clinical Director of the New York University Gender and Sexuality Service, which I founded in 2011.

8. I am Board Certified in Child, Adolescent, and Adult Psychiatry. In my clinical practice, I have seen approximately 500 transgender patients.

9. I am an Associate Editor of the peer-reviewed publication *Transgender Health*. I am also a reviewer for *LGBT Health* and *Journal of the American Academy of Child and Adolescent Psychiatry*, both of which are peer-reviewed journals.

10. I am the author or co-author of 16 articles on care for transgender patients and am the co-author of *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, Springer Publishing, 2018. I have also authored or co-authored numerous book chapters on treatment for transgender adults and youth.

11. I have been a member of the World Professional Association for Transgender Health ("WPATH") since 2011. I have been actively involved in WPATH's revision of its Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People ("Standards of Care"), serving as a member of revision committees for both the child and adult mental health chapters of the forthcoming eighth edition of WPATH's Standards of Care.

12. I am involved in a number of international, national, and regional committees that contribute to the scholarship and provision of care to transgender people. I am the Chair of the American Academy of Child and Adolescent Psychiatry's Sexual Orientation and Gender Identity Committee. I serve as a member of the Transgender Health Committee for the Association of Gay and Lesbian Psychiatrists. I also am the Founder and Director of the Gender Variant Youth and Family Network.

13. I have not testified as an expert at trial or by deposition in the last four years.

14. I am being compensated for my work on this matter at a rate of $400 per hour for preparation of this report and for time spent preparing for and giving local deposition or trial testimony. In addition, I would be compensated $2,500 per day for deposition or trial testimony

requiring travel and $300 per hour for time spent travelling, plus reasonable expenses. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

SUMMARY OF OPINIONS

15. My understanding is that this case is a legal challenge to a West Virginia law ("H.B. 3293") that prohibits girls and women who are transgender from participating on girls' and women's sports teams in "[i]nterscholastic, intercollegiate, intramural, or club athletic teams or sports that are sponsored by any public secondary school or a state institution of higher education." W. Va. Code § 18-2-25d(c)(1). In their expert reports, Dr. Levine and Dr. Cantor do not offer any expert opinions directly relating to H.B. 3293 or the participation of transgender athletes. Instead, Dr. Levine and Dr. Cantor launch a broadside attack against the prevailing model of gender-affirming care for transgender youth that has been endorsed by the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, and the American Medical Association, among many other mainstream medical organizations.

16. As an initial matter, it is important to note that Dr. Levine and Dr. Cantor's litany of criticisms are largely irrelevant to the population of people affected by H.B. 3293. Most of Dr. Levine and Dr. Cantor's arguments relate to (a) prepubertal children who "desist" from expressing a transgender identity once they reach puberty and (b) transgender boys who first seek treatment for gender dysphoria during adolescence. But H.B. 3293 does not affect elementary school students or transgender boys. It affects transgender girls and women in middle school, high school, and college.

17. As I explain in this report, Dr. Levine and Dr. Cantor's criticisms are also utterly unfounded. First, Dr. Levine and Dr. Cantor lack experience with gender dysphoria in children and adolescents—the groups whom their reports discuss.

18. Second, with respect to prepubertal children, Dr. Levine and Dr. Cantor present a caricatured description of prevailing standards of care that reflects a profound misunderstanding of the subject. Gender-affirming care for prepubertal children is not synonymous with "transition on demand" (Cantor Rep. ¶ 45) or a rubber-stamp recommendation that every prepubertal child expressing feelings of gender dysphoria be encouraged to socially transition. Treatment is individualized based on the needs of the child and the family and other psychosocial considerations and is decided upon only after a discussion of possible benefits and risks. For prepubertal transgender children with intense, persistent gender dysphoria, there is substantial evidence that, in appropriate cases, socially transitioning can have significant mental health benefits.

19. Third, Dr. Levine and Dr. Cantor's criticisms of gender-affirming care for adolescents—like their criticisms of gender-affirming care for prepubertal children—also reflect a distorted interpretation of the relevant scientific literature and a caricatured understanding of what gender-affirming care is. Studies have repeatedly documented that puberty-blocking medication and gender-affirming hormone therapy are associated with mental health benefits in both the short and long term. Contrary to the portrayal in Dr. Levine and Dr. Cantor's reports, gender-affirming treatment also requires a careful and thorough assessment of a patient's mental health, including co-occurring conditions, history of trauma, and substance use, among many other factors.

20. Finally, while purporting to offer expert opinions on mental health care for transgender youth, Dr. Levine and Dr. Cantor do not appear to offer any expert opinions on the mental health impact of H.B. 3293 itself. Excluding transgender adolescent girls and women from

female sports teams will not cure their gender dysphoria or improve their mental health. To the contrary, stigma and discrimination have been shown to have a profoundly harmful impact on the mental health of transgender people and other minority groups.

DISCUSSION

Dr. Levine and Dr. Cantor Lack Experience with Gender Dysphoria in Children and Adolescents

21. According to his CV, Dr. Levine is not board certified in child and adolescent psychiatry, which requires specialized training in child development that is essential for working with transgender young people and their families. His declaration and CV also indicate that he does not have significant clinical experience working with adolescents experiencing gender dysphoria, the patient population at the heart of this case.

22. Moreover, Dr. Levine repeatedly acknowledges in his report that he has no first-hand knowledge of how gender-affirming mental health care is actually provided to children and adolescents. His descriptions are based on second-hand conversations and often sensationalized media reports. (*See, e.g.*, Levine Rep. ¶¶ 49, 118 (offering opinions based on anecdotal reports from the internet).)

23. Dr. Cantor appears to have no experience in child or adolescent psychology and no relevant experience with respect to gender dysphoria in childhood and adolescence. His academic career has focused on pedophilia and sexual paraphilias in adults.

Gender-Affirming Care for Prepubertal Children

24. Dr. Levine and Dr. Cantor devote substantial portions of their expert reports to criticizing the positions of mainstream medical organizations with respect to gender-affirming care for prepubertal transgender children. (*See, e.g.*, Levine Rep. ¶¶ 42-43, 114-17, 130-34; Cantor Rep. ¶¶ 36-45, 82-87.) According to Dr. Levine and Dr. Cantor, studies have indicated that gender dysphoria in prepubertal children may desist by the time the children reach puberty, and thus

medical professionals should adopt a "watchful waiting" approach and avoid affirming a prepubertal child's gender identity.

25. Before addressing Dr. Levine and Dr. Cantor's arguments about prepubertal children, it is important to emphasize that those arguments are irrelevant to what I understand to be the issues in this case. H.B. 3293 does not apply to elementary schools, and the plaintiff in this case is an 11-year-old middle school student. The relevant population affected by H.B. 3293 is composed of transgender adolescents and young adults, not prepubertal children.

26. With respect to prepubertal children, Dr. Levine and Dr. Cantor present a caricatured description of prevailing standards of care that reflects a profound misunderstanding of the subject. Mental health providers cannot change a prepubertal child's gender identity or prevent them from being transgender, just as mental health providers cannot change a cisgender child's gender identity. Prepubertal children who "desist" are children with non-conforming gender expression who realize with the onset of puberty that their gender identity is consistent with their sex assigned at birth. Their understanding of their gender identity changes with the onset of puberty, but their gender identity does not. We cannot definitively determine which prepubertal children will go on to identify as transgender when they reach adolescence, but we know that children with gender dysphoria who persist into puberty are more likely to have expressed a consistent, persistent, and insistent understanding of their gender identity from a young age.[1]

27. Gender-affirming care for prepubertal children is not synonymous with "transition on demand" (Cantor Rep. ¶ 45) or a rubber-stamp recommendation that every prepubertal child expressing feelings of gender dysphoria be encouraged to socially transition. Treatment is

[1] Steensma, T.D., *et al*. (2013). *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*. J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY. 52(6):582-90 ("Steensma 2013").

individualized based on the needs of the child and the family and other psychosocial considerations, and is decided upon only after a discussion of possible benefits and risks.[2] As part of those discussions, the child and their family are advised that prepubertal children do not always go on to identify as transgender when they reach adolescence, and that children are encouraged to continue developing an understanding of their gender identity without expectation of a specific outcome even after social transition takes place.[3]

28. The focus of gender-affirming care is supporting overall health and wellbeing, regardless of whether the young person continues to identify as transgender. In this manner, the primary goal of gender-affirming care is to help a child understand their own gender identity and build resilience and mental wellness in a child and family, without privileging any one outcome over another.

29. Important considerations in deciding whether social transition is in a child's best interest include: whether there is a consistent, stable articulation of a gender different from the child's sex assigned at birth, which should be distinguished from merely dressing or acting in a gender non-conforming manner; whether the child is expressing a strong desire or need to transition; the degree of distress the child is experiencing as a result of the gender dysphoria; and whether the child will be emotionally and physically safe during and following transition.[4]

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[2] *See* Hidalgo, M.A., *et al*. (2013). *The Gender Affirmative Model: What We Know and What We Aim to Learn*. HUMAN DEV. 56(5):285-90.

[3] *See* American Psychological Association. (2015). *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. AM. PSYCHOLOGIST. 70(9):832-64 ("APA 2015"); Edwards-Leeper, L., & Spack, N.P. (2012). *Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center*. J. HOMOSEXUALITY. 59(3):321-36 ("Edwards-Leeper 2012").

[4] APA 2015.

30. A treatment plan is informed by a psychosocial assessment, which may vary greatly depending on the patient's presentation and the complexity of the issues the patient is navigating. Further, in conducting that assessment, the mental health provider is drawing from their professional training and experience in working with transgender young people, exercising professional judgment, and tailoring the assessment to each individual patient.

31. There is also no requirement that prepubertal children who socially transition receive mental health therapy. Many prepubertal children who express a gender identity different from their sex assigned at birth do not experience any co-occurring conditions or other psychological distress requiring treatment.[5] Mental health therapy may be useful for some prepubertal children but is not necessary or appropriate for everyone. Forcing children to undergo therapy when it is not medically indicated is both harmful and unethical.

32. What makes gender-affirming care "gender affirming" is that it does not presume that being transgender is incompatible with a young person's short- and long-term health and wellbeing. Simply being transgender or gender nonconforming is not a medical condition or pathology to be treated. As the DSM-5 recognizes, diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 451 (2013). The DSM-5 unequivocally repudiated the outdated view that being transgender is a pathology by revising the diagnostic criteria (and name) of gender dysphoria to recognize the clinical distress as the focus of the treatment, not the patient's transgender status.

[5] *See* Levine Rep. ¶ 30 (acknowledging that "[y]oung children who are living a transgender identity commonly suffer materially fewer symptoms of concurrent mental distress than do older patients."); de Vries, A.L.C, *et al*. (2011). *Psychiatric comorbidity in gender dysphoric adolescents*. J. CHILD PSYCHOLOGY & PSYCHIATRY. 52(11):1195-202 (noting that 67.6% had no concurrent psychiatric disorder).

33. In criticizing what they imagine to be gender-affirming care, Dr. Levine and Dr. Cantor do not merely advocate for "watchful waiting" to see whether dysphoria persists into adolescence before any treatment is provided. Instead, they offer wild speculation that mental health professionals can and should intervene and provide therapy to encourage the patient to identify with their sex assigned at birth, which they believe will reduce the likelihood that gender dysphoria will persist. Both Dr. Levine and Dr. Cantor candidly admit that there is no credible scientific research indicating that such practices are either possible or ethical. (*See* Levine Rep. ¶ 49 ("To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women."); Cantor Rep. ¶ 42 (speculating that "therapeutic intervention [could] facilitate or speed desistance" while admitting "there has not yet been any such study").)

34. Although Dr. Levine refers to his preferred modality as the "psychotherapy model" (Levine Rep. ¶¶ 46-48), this approach is more appropriately characterized as the "gender identity conversion model" because its goal is to bring the patient's gender identity into alignment with their assigned sex and foreclose gender transition as a treatment for gender dysphoria. A recent study found that people who reported experiencing those conversion efforts were more likely to have reported attempting suicide, especially those who reported receiving such therapy in childhood.[6] That conclusion is further supported by the extensive evidence that rejection of a young person's gender identity by family and peers is the strongest predictor for adverse mental

[6] Turban, J.L., *et al*. (2020). *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*. JAMA PSYCHIATRY. 77(1):68-76.

health outcomes.[7] Attempting to change a person's gender identity is not an appropriate therapeutic modality, and such practices have been widely recognized as discredited, harmful, and ineffective.[8]

35. In contrast, for prepubertal transgender children with intense, persistent gender dysphoria, there is substantial evidence that, in appropriate cases, socially transitioning can have significant mental health benefits. While not true for every transgender child, transgender children as a group have higher rates of depression, anxiety, and suicidal thoughts and behaviors. Research indicates that social transition significantly improves the mental health of transgender young people, bringing their mental health profiles into close alignment with their non-transgender peers, finding only slightly higher levels of anxiety and no elevated levels of depression.[9]

36. Dr. Levine and Dr. Cantor criticize research demonstrating the benefits of social transition and argue that even after socially transitioning, transgender youth as a group can

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[7] Ryan, C., *et al*. (2010). *Family Acceptance in Adolescence and the Health of LGBT Young Adults*. J. CHILD ADOLESC. PSYCHIATRIC NURSING. 23(4):205-13; Klein, A., & Golub, S.A. (2016). *Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults*. LGBT HEALTH. 3(3):193-99.

[8] *See* American Academy of Child & Adolescent Psychiatry Policy Statement: Conversion Therapy (2018); American Psychiatric Association Position Statement on Conversion Therapy and LGBTQ Patients (2018); American Psychological Association Resolution on Gender Identity Change Efforts (2021).

[9] *See* Gibson, D.J., *et al*. (2021). *Evaluation of Anxiety and Depression in a Community Sample of Transgender Youth*. JAMA NETWORK OPEN. 4(4):e214739; Durwood, L., *et al*. (2017). *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*. J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY. 56(2):116-23; Olson, K.R., *et al*. (2016). *Mental Health of Transgender Children Who Are Supported in Their Identities*. PEDIATRICS. 137(3):e20153223 ("Olson 2016").

Dr. Cantor points to a critique of Olson 2016 which attempted—unsuccessfully—to show statistical errors in the paper. (Cantor Rep. ¶¶ 15-16, 100 (citing Schumm, W. R., & Crawford, D.W. (2020). *Is Research on Transgender Children What It Seems? Comments on Recent Research on Transgender Children with High Levels of Parental Support*. THE LINACRE QUARTERLY. 87(1):9-–24).) The small statistical errors in Olson 2016 had already been corrected in 2018 and did not alter any of the study's findings. *See* Olson, K.R., *et al.* (2018). *Mental Health of Transgender Children Who Are Supported in Their Identities* (Errata). PEDIATRICS. 142(2):e20181436.

experience higher rates of anxiety and depression than cisgender children of the same age. To be sure, stigma and discrimination have been shown to have a profoundly harmful impact on mental health of transgender people and other minority groups.[10] But preventing a child from socially transitioning does not prevent the child from being transgender, and social transition is a treatment for gender dysphoria, not a panacea for all co-occurring mental health concerns. Dr. Levine and Dr. Cantor offer no support whatsoever for their apparent assumption that mental health outcomes would be improved by preventing social transition from occurring.

37. There is also no evidence supporting Dr. Levine's speculation that allowing prepubertal children to socially transition puts children on a "conveyor belt" path to becoming transgender adolescents and adults. (*See* Levine Rep. ¶¶ 131-34.) Rather, the evidence shows that the same prepubertal children who are likely to have a stable transgender identity into adolescence are the children who are most likely to articulate a strong and consistent need to socially transition.[11] For example, a recent study found that a group of transgender children who transitioned before puberty and a group of transgender children who waited to transition until after puberty both showed the same intensity of cross-gender identification. In other words, socially transitioning before puberty did not increase children's cross-gender identification, and deferring transition did not decrease cross-gender identification.[12] Intense cross-gender identification and a strong, persistent desire to transition is simply an indicator that a child is more likely to be transgender and not merely gender nonconforming.

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[10] White Hughto, J.M., *et al*. (2015). *Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions*. SOC. SCI. MED. 147:222-31 ("White Hughto 2015").

[11] Steensma 2013.

[12] Rae, J.R., *et al*. (2019). *Predicting Early-Childhood Gender Transitions*. PSYCHOLOGICAL SCI. 30(5):669-81.

Gender-Affirming Care for Adolescents

38. Dr. Levine and Dr. Cantor also devote much of their reports to criticizing the provision of gender-affirming care for adolescents, arguing that the benefits of puberty-blocking medication are overstated and that adolescents should have more rigorous mental health screening. As with their criticisms of gender-affirming care for prepubertal children, Dr. Levine and Dr. Cantor do not explain how any of their criticisms are relevant to the issue of whether girls and women who are transgender should be able to participate on female sports teams in secondary school and college.

39. Dr. Levine and Dr. Cantor's criticisms of gender-affirming care for adolescents—like their criticisms of gender-affirming care for prepubertal children—also reflect a distorted interpretation of the relevant scientific literature and a caricatured understanding of what gender-affirming care is. Despite Dr. Levine's suggestion to the contrary, there is no "watchful waiting" approach for transgender adolescents. Even practitioners who oppose social transition in childhood provide gender-affirming care for transgender adolescents, including puberty-blocking medication and gender-affirming hormone treatments for gender dysphoria.[13] As with their criticism of care for prepubertal children, Dr. Levine and Dr. Cantor criticize the methodology of studies supporting gender-affirming care while proposing a "therapy only" treatment without any empirical or scientific support whatsoever.

40. Studies have repeatedly documented that puberty blocking medication and gender-affirming hormone therapy are associated with mental health benefits in both the short and long

[13] Jack Turban, Annelou DeVries & Kenneth Zucker, "Gender Incongruence & Gender Dysphoria," in *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook* (A Martin, *et al*., eds., 5th ed., 2018).

term.[14] In addition to forestalling increased distress and dysphoria resulting from the physical changes accompanying puberty, puberty-delaying medication followed by gender-affirming hormones brings a transgender person's body into greater alignment with their identity over the long term and reduces the number of surgeries a transgender person may need as an adult. The benefits of puberty-blocking medication thus increase over the long term as the person progresses into adulthood.[15]

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[14] *See* Tordoff, D.M., *et al*. (2022). *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*. JAMA NETWORK OPEN. 5(2):e220978 at 1 (finding that receipt of gender-affirming care, including puberty blockers and gender-affirming hormones, was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up); Green, A.E., *et al.* (2021). *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*. J. ADOLESC. HEALTH [ePublication ahead of print] at 1 (finding that access to gender-affirming hormones during adolescence was associated with lower odds of recent depression and having attempted suicide in the past year); Turban, J.L., *et al*. (2020) *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*. PEDIATRICS. 145(2):e20191725 at 1 (finding that access to puberty blockers during adolescence is associated with a decreased lifetime incidence of suicidal ideation among adults); Achille, C., *et al*. (2020). *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results*. INT'L J. PEDIATRIC ENDOCRINOLOGY. 2020:8 at 1 (finding that endocrine intervention was associated with decreased depression and suicidal ideation and improved quality of life for transgender youth); Kuper, L.E., *et al*. (2020). *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*. PEDIATRICS. 145(4):e20193006 at 1 (showing hormone therapy in youth is associated with reducing body dissatisfaction and modest improvements in mental health); van der Miesen, A.I.R., *et al*. (2020). *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*. J. ADOLESC. HEALTH. 66(6):699-704 at 699 (showing fewer emotional and behavioral problems after puberty suppression, and similar or fewer problems compared to same-age cisgender peers) ("van der Miesen 2020"); Costa, R., *et al*. (2015). *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*. J. SEXUAL MEDICINE. 12(11):2206-14 at 2206 (finding increased psychological function after six months of puberty suppression); de Vries, A.L.C., *et al*. (2014). *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*. PEDIATRICS. 134(4):696-704 (following a cohort of transgender young people in the Netherlands from puberty suppression through surgical treatment and finding that the cohort had global functioning that was equivalent to the Dutch population) ("de Vries 2014").

[15] de Vries 2014.

41. Dr. Cantor fails to discuss many of the studies documenting the benefits of puberty-blocking medication. For the studies he does discuss, Dr. Cantor's primary criticism is that many of the prospective cohort studies offered psychosocial support in addition to puberty blockers and hormones, which prevented the study from isolating whether the benefit is associated with the puberty blocker, the gender-affirming hormones, or some combination. (Cantor Rep. ¶¶ 64, 66.) But, as Dr. Cantor himself notes, elsewhere "in medical research, where we cannot manipulate people in ways that would clear up difficult questions, all studies will have a fault. In science, we do not, however, reject every study with any identifiable short-coming—rather, we gather a diversity of observations, made with their diversity of compromises to safety and ethics (and time and cost, etc.)." (Cantor Rep. ¶ 87.) When viewed as a comprehensive body of research, the weight of the evidence and the experience of clinicians has demonstrated that puberty-blocking medication and hormones have been associated with a variety of mental health benefits across different contexts.

42. There is also no credible basis for Dr. Levine's assertion that an adolescent's decision to begin puberty-blocking medication "act[s] as a psychosocial 'switch,' decisively shifting many children to a persistent transgender identity." (Levine Rep. ¶ 137.) Studies showing that a high percentage of transgender adolescents who receive puberty blockers ultimately decide to move forward with gender-affirming hormone therapy more likely reflect the fact that participants were rigorously screened and had demonstrated sustained, persistent gender dysphoria before receiving medical treatment.

43. Instead of addressing the proper treatment for transgender adolescents in need of care, Dr. Levine and Dr. Cantor devote most of their attention to the possibility that a person could be misdiagnosed with gender dysphoria and then later regret their medical transition. For example, Dr. Levine and Dr. Cantor devote a great deal of space to discussing a theory that an increasing

number of people who are assigned female at birth are suddenly identifying as males in mid-to-late adolescence as a result of peer pressure and social contagion. (Levine Rep. ¶¶ 38, 118-20; Cantor Rep. ¶¶ 73-74.) The theory that some adolescents experience "rapid-onset gender dysphoria" (Levine Rep. ¶ 118; Cantor Rep. ¶¶ 73-74) as a result of social influences is based almost exclusively on one highly controversial study.[16] Although purporting to provide a basis for Dr. Levine's speculations, the study was based on an anonymous survey, allegedly of parents, about the etiology of their child's gender dysphoria. Participants were recruited from websites promoting this social contagion theory, and the children were not surveyed or assessed by a clinician. Those serious methodological flaws render the study meaningless. The only conclusion that can be drawn from that study is that a self-selected sample of anonymous people recruited through websites that predisposed participants to believe transgender identity can be influenced by social factors do, in fact, believe those social factors influence children to identify as transgender.[17]

44. Some transgender people who do not come forward until adolescence may have experienced symptoms of gender dysphoria for long periods of time but been uncomfortable disclosing those feelings to parents. Other transgender people do not experience distress until they experience the physical changes accompanying puberty. In either case, gender-affirming care requires a comprehensive assessment and persistent, sustained gender dysphoria before medical treatment is prescribed.

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[16] *See* Littman, L. (2018). *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*. PLoS ONE. 13(8):e0202330.

[17] Aside from these serious methodological flaws, Littman's hypothesis of "rapid onset gender dysphoria" focuses specifically on gender dysphoria in boys who are transgender and were assigned a female sex at birth. By contrast, the restrictions in H.B. 3293 are limited to girls and women who are transgender and were assigned a male sex at birth. As with their arguments about prepubertal children, Dr. Levine and Dr. Cantor's arguments about boys who are transgender are not relevant to the population actually affected by H.B. 3293.

45. Contrary to the portrayal in Dr. Levine and Dr. Cantor's reports, gender-affirming treatment also requires a careful and thorough assessment of a patient's mental health, including co-occurring conditions, history of trauma, and substance use, among many other factors.[18] As a result, I have had patients who presented with some symptoms of gender dysphoria, but who ultimately did not meet the diagnostic criteria for a variety of reasons, and therefore I recommended treatments other than transition to alleviate their psychological distress.

46. Dr. Levine and Dr. Cantor also devote substantial space to discussing the possibility that a person could be misdiagnosed with gender dysphoria instead of another mental health condition. (*See, e.g.* Levine Rep. ¶¶ 118-26; Cantor Rep. ¶¶ 73-74, 76-80.) Studies on transgender young people have long reported data on co-occurring conditions. Indeed, Dr. Cantor specifically cites to one of my own articles on the topic. (Cantor Rep. ¶ 76 (citing Janssen, A., *et al*. (2019). *The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study*. ARCHIVES OF SEXUAL BEHAVIOR. 48(7):2003-09).)

47. The existence—and prevalence—of co-occurring conditions among transgender young people is unsurprising. Transgender young people must cope with many stressors, from the fear of rejection by family and peers to pervasive societal discrimination. Not to mention, their underlying gender dysphoria can cause significant psychological distress which, if left untreated, can result in or exacerbate the co-occurring conditions identified in studies on transgender young people.[19] And, given that transgender young people typically delay disclosing their transgender status or initially experience family rejection following disclosure, it is not uncommon for

[18] Olson-Kennedy, J., *et al*. (2019). *Creating the Trans Youth Research Network: A Collaborative Research Endeavor.* TRANSGENDER HEALTH. 4(1):304-12; Edwards-Leeper 2012.

[19] van der Miesen 2020; Turban, J.L., *et al*. (2021). *Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes*. J. ADOLESC. HEALTH. 69(6):991-98.

transgender young people to engage with psychological or psychiatric care for other reasons prior to being diagnosed with gender dysphoria.

48. Requiring that a transgender patient resolve all co-occurring conditions, many of which are chronic with no reasonable expectation that they be "resolved," prior to receiving gender-affirming care—as suggested by Dr. Cantor—is not possible, nor is it ethical. (Cantor Rep. ¶¶ 14, 35, 69, 92, 110.) No relevant organizations cite the need for co-occurring mental health conditions to be resolved before a patient may receive gender-affirming care. Rather, such conditions should be reasonably well-controlled and not impair the ability of the patient to make an informed decision or interfere with the accuracy of the diagnosis of gender dysphoria. Indeed, some co-occurring conditions (for example, Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder, to name a few) could be chronic disorders where complete resolution is impossible and the goal of treatment is mitigating harm and improving functioning,

49. It is important to note that distress associated with untreated gender dysphoria can also amplify co-occurring conditions that developed independently of the gender dysphoria. Thus, treating the underlying gender dysphoria is essential to alleviating the psychological distress associated with co-occurring conditions.

Discriminating Against Transgender Students Does Not Improve Their Mental Health

50. The overarching theme of Dr. Levine and Dr. Cantor's reports is that transgender people as a group have greater rates of a variety of negative social outcomes and co-occurring conditions over the course of their lives and that, to avoid those negative outcomes and conditions, mental health providers should withhold gender-affirming care to discourage transgender youth from growing into transgender adults.[20]

[20] Dr. Levine bizarrely speculates that once a transgender person's siblings "marry and have children," they will not "wish the transgender individual to be in contact with those children," and

51. Discriminating against transgender people, or withholding gender-affirming care, will not prevent those people from being transgender. And excluding transgender adolescent girls and women from female sports teams will not cure their gender dysphoria or improve their mental health. To the contrary, as noted previously, stigma and discrimination have been shown to have a profoundly harmful impact on the mental health of transgender people and other minority groups.[21]

52. No reasonable mental health professional with relevant experience treating children and adolescents could conclude that H.B. 3293 is anything but harmful to the mental health of transgender youth. Exclusion and isolation are harmful for all adolescents, but particularly so for transgender youth who face the additional burden of societal stigma. Preventing transgender youth from participating in the same activities as their peers—or forcing transgender youth to be treated inconsistent with their gender identity—undermines their ability to socially transition and prevents transgender youth from accessing important educational and social benefits of the school environment.[22]

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that transgender people will be less likely to find "individuals willing to develop a romantic and intimate relationship with them." (Levine Rep. ¶¶ 202-03.) Dr. Levine offers no statistical support for these assertions and, in my experience, clinical practice has shown the opposite to be true.

[21] White Hughto 2015.

[22] American Psychological Association Resolution on Supporting Sexual/Gender Diverse Children and Adolescents in Schools (2020) at 5 (supporting inclusion of transgender youth in school activities and sports consistent with their gender identity); Clark, C.M., & Kosciw, J.G. (2022). *Engaged or excluded: LGBTQ youth's participation in school sports and their relationship to psychological well-being*. PSYCHOLOGY IN THE SCHOOLS. 59:95-114 (finding transgender youth who participated in sports had increased well-being and greater school belonging).

CONCLUSION

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 3/10/2022

Aron Janssen, MD

Curriculum Vitae

Aron Janssen, M.D.
312-227-7783
aronjans@gmail.com

Personal Data

Born	Papillion, Nebraska
Citizenship	USA

Academic Appointments

2011-2017	Clinical Assistant Professor of Child and Adolescent Psychiatry
2011-2019	Founder & Clinical Director, NYU Gender and Sexuality Service Director, LGBT Mental Health Elective, NYULMC
2015-2019	Co-Director, NYU Pediatric Consultation Liaison Service New York University Department of Child and Adolescent Psychiatry
2017-present	Clinical Associate Professor of Child and Adolescent Psychiatry
2019-present	Vice Chair, Pritzker Department of Psychiatry and Behavioral Health Ann and Robert H. Lurie Children's Hospital of Chicago
2020-present	Medical Director, Outpatient Psychiatric Services Ann and Robert H. Lurie Children's Hospital of Chicago

Education

Year	Degree	Field	Institution
6/97	Diploma		Liberty High School
5/01	B.A.	Biochemistry	University of Colorado
5/06	M.D.	Medicine	University of Colorado

Postdoctoral Training

2006-2009	Psychiatry Residency	Ze'ev Levin, M.D.	NYU Department of Psychiatry
2009-2011	Child and Adolescent Psychiatry Fellowship – Fellow and Clinical Instructor		
		Jess Shatkin, M.D.	NYU Dept of Child/Adolescent Psychiatry

Licensure and Certification

2007-present	New York State Medical License
2011-present	Certification in Adult Psychiatry, American Board of Psychiatry and Neurology
2013-present	Certification in Child and Adolescent Psychiatry, ABPN

Academic Appointments

2009-2011	Clinical Instructor, NYU Department of Child and Adolescent Psychiatry
2011-2017	Clinical Asst Professor, NYU Dept of Child and Adolescent Psychiatry
2017-2019	Clinical Assoc Professor, NYU Dept of Child and Adolescent Psychiatry
2011-present	Clinical Director, NYU Gender and Sexuality Service
2015-2019	Co-Director, NYU Pediatric Consultation-Liaison Service
2019-present	Associate Professor of Child and Adolescent Psychiatry, Northwestern University
2019-present	Vice Chair of Clinical Affairs, Pritzker Department of Psychiatry and Behavioral Health, Lurie Children's Hospital of Chicago

Major Committee Assignments

International, National and Regional

2021-present	Sexual Orientation and Gender Identity Committee, Chair, AACAP
2019-present	WPATH Standards of Care Revision Committee, Children
2019-present	WPATH Standards of Care Revision Committee, Adult Mental Health
2015-2019	Department of Child Psychiatry Diversity Ambassador
2013-2021	Sexual Orientation and Gender Identity Committee Member, AACAP
2012-present	Founder and Director, Gender Variant Youth and Family Network
2012-present	Association of Gay and Lesbian Psychiatrists, Transgender Health Committee
2012-2019	NYULMC, Chair LGBTQ Advisory Council
2012-2019	NYULMC, Child Abuse and Protection Committee
2013-2015	NYULMC, Pediatric Palliative Care Team
2003-2004	American Association of Medical Colleges (AAMC), Medical Education Delegate
2004-2006	AAMC, Western Regional Chair

Psychiatry Residency

2006-2009	Resident Member, Education Committee
2007-2008	Resident Member, Veterans Affairs (VA) Committee

Medical School

2002-2006	Chair, Diversity Curriculum Development Committee
2002-2006	AAMC, Student Representative
2003-2004	American Medical Student Assoc. (AMSA) World AIDS Day Coordinator
2003-2004	AMSA, Primary Care Week Coordinator
2004-2006	Chair, Humanism in Medicine Committee

Memberships, Offices, and Committee Assignments in Professional Societies

2006-present	American Psychiatric Association (APA)
2009-present	American Academy of Child and Adolescent Psychiatry (AACAP)
2011-present	World Professional Association for Transgender Health (WPATH)
2011-present	Director, Gender Variant Youth and Family Network, NYC
2013-2019	Chair, NYU Langone Medical Center LGBTQ Council
2015-present	Clinical Associate Editor, *Transgender Health*

Editorial Positions

2016-present	Clinical Assistant Editor, *Transgender Health*
2014-present	Ad Hoc Reviewer, *LGBT Health.*
2016-present	Ad Hoc Reviwer, *JAACAP*
2018-present	Associate Editor, *Transgender Health*

Principal Clinical and Hospital Service Responsibilities

2011-2019	Staff Psychiatrist, Pediatric Consultation Liaison Service
2011-2019	Faculty Physician, NYU Child Study Center
2011-2019	Founder and Clinical Director, NYU Gender & Sexuality Service
2015-2019	Co-Director, Pediatric Consultation Liaison Service
2019-present	Vice Chair, Pritzker Dept of Psychiatry and Behavioral Health
2019-present	Chief Psychiatrist, Gender Development Program

2020-present Medical Director, Outpatient Psychiatry Services

Relevant Program Development

Gender and Sexuality Service

-founded by Aron Janssen in 2011, who continues to direct the service
-first mental health service dedicated to transgender youth in NYC
-served over 200 families in consultation, with 2-3 referrals to the gender clinic per week
-trained over 500 mental health practitioners in transgender mental health – 1 or 2 full day trainings in partnership with the Ackerman Institute's Gender and Family Project (GFP) and with WPATH Global Educational Initiative (GEI)
-New hires in Adolescent Medicine, Psychology, Plastic Surgery, Urology, Gynecology, Endocrinology, Social Work, Department of Population Health with focus on transgender care has led to expansion of available services for transgender youth at NYULMC in partnership with the Gender and Sexuality Service
-development of partnerships with Ackerman Institute, Callen-Lorde Health Center – both institutions have been granted access to our IRB and have agreed to develop shared research and clinical priorities with the Gender and Sexuality Service. Two active projects are already underway
-multiple IRB research projects underway, including in partnership with national and international clinics
-model has been internationally recognized

Clinical Specialties/Interests

Gender and Sexual Identity Development
Co-Occurring Mental Health Disorders in Transgender children, adolescents and adults
Pediatric Consultation/Liaison Psychiatry
Psychotherapy
-Gender Affirmative Therapy, Supportive Psychotherapy, CBT, MI

Teaching Experience

2002-2006 Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine
2011-2019 Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year
2011-2019 Course Director, Instructor "Sex Matters: Identity, Behavior and Development" – 100 hours per year
2011-2019 Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry) - 50 hours of direct supervision/instruction per year
2011-2019 Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018.
2015-2019 Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies

-Teacher and Course Director: "Sex Matters: Identity, Behavior and Development." A full semester 4 credit course, taught to approximately 50 student per year since

2011, with several students now in graduate school studying sexual and gender identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry
-Instructor: Cultural Competency in Child and Adolescent Psychiatry
-Director: LGBTQ Mental Health Elective
World Professional Association of Transgender Health
-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., "A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients," Journal of the American Academy of Child and Adolescent Psychiatry, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. "Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., Transgender Health. February 2016, "Gender Variance Among Youth with Autism: A Retrospective Chart Review." 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. Transgender Health. July 2017, 2(1): 96-106.
5. Janssen A., et. al., "Gender Variance Among Youth with ADHD: A Retrospective Chart Review," in review
6. Janssen A., et. al., "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents," Journal of Child & Adolescent Psychology, 105-115, January 2018.
7. Janssen A., et. al., "A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder," Transgender Health, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., "'The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., "Ethical Issues in Gender-Affirming Care for Youth," Pediatrics, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., "Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals," Journal of the American Academy of Child and Adolescent Psychiatry, 2018 Nov;57(11):885-887.
11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, "Using global positioning system methods to explore mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City," Geospatial Health, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., "Seizure-like episodes, but is it really epilepsy?" Current Psychiatry. 2019 Aug; 18(8): 42-47.

13. Janssen, A., Busa, S., Wernick, J., "The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior. 2019 Oct; 48(7): 2003-2009.
14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, "A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery," Urol Clin North Am. 2019 Nov; 46(4): 475-486.
15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology.* DOI 10.1080/15374416.2020.1731817
16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. Evidence-based Practice in Child and Adolescent Mental Health.
17. Janssen, A., Voss, R.. Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. Transgender Health.
18. Dubin, S., Cook, T., Liss, A., Doty, G., Moore, K., Janssen, A. (In press 2020). Comparing Electronic Health Records Domains' Utility to Identify Transgender Patients. Transgender Health, DOI 10.1089/trgh.2020.0069

Published Abstracts

1. Thrun, M., Janssen A., et. al. "Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses," original research poster presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.
2. Janssen, A., "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., "Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists," 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.
4. Janssen, A., "When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," AACAP Annual Meeting, October 2014.
5. Janssen, A., "Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center," Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., "How much is too much? Assessments & the Affirmative Approach to TGNC Youth," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.

7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.
17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et. al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.
20. Janssen, A., "Gender Diversity and Gender Dysphoria in Youth," EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., "The Good, The Bad, and The Risky: Sexual Behaviors Online," AACAP Annual Conference, October 2020
22. Englander, E., Janssen, A., et. al., "Love in Quarantine," AACAP Annual Conference, October 2021
23. Janssen, A., Leibowitz, S., et. al., "The Evidence and Ethics for Transgender Youth Care: Updates on the International Standards of Care, 8th Edition," AACAP Annual Conference, October 2021
24. Turban, J., Janssen, A., et. al., "Transgender Youth: Understanding "Detransition," Nonlinear Gender Trajectories, and Dynamic Gender Identities," AACAP Annual Conference, October 2021

Books

1. Janssen, A., Leibowitz, S (editors), Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook, Springer Publishing, 2018.

Book Chapters

1. Janssen, A., Shatkin, J., "Atypical and Adjunctive Agents," Pharmacotherapy for Child and Adolescent Psychiatric Disorders, 3rd Edition, Marcel Dekker, Inc, New York, 2012.
2. Janssen, A; Liaw, K: "Not by Convention: Working with People on the Sexual & Gender Continuum," book chapter in The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health. Humana Press, New York, Editor R. Parekh, January 2014.
3. Janssen, A; Glaeser, E., Liaw, K: "Paving their own paths: What kids & teens can teach us about sexual and gender identity," book chapter in Cultural Sensitivity in Child and Adolescent Mental Health, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., "Gender Identity," Textbook of Mental and Behavioral Disorders in Adolescence, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) Gender Dysphoria in Childhood. Encyclopedia of Child and Adolescent Development. Wiley, 2018.
6. Janssen A., Busa S., "Gender Dysphoria in Childhood and Adolescence," Complex Disorders in Pediatric Psychiatry: A Clinician's Guide, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.RL. "Not by Convention: Working with People on the Sexual and Gender Continuum." Book chapter in The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma.* 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., "Child and Adolescent Medicine," The Equal Curriculum: The Student and Educator Guide to LGBTQ Health, editors Lehman J., et al. November 2019.
10. Janssen, A., et. al., "Gender and Sexual Diversity in Childhood and Adolescence," Dulcan's Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., "Gender Dysphoria," The Encyclopedia of Child and Adolescent Development, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: "How to Talk to a Gay Medical Student" – presented at the National AAMC Meeting.
2. March 2011: "Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators" – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., "Sex Matters: Identity, Behavior and Development," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.

4. March 2012: Janssen, A., Lothringer, L., "Gender Variance in Children and Adolescents," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: "Gender Variance in Childhood and Adolescence," Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, NYU Department of Endocrinology.
9. October, 2014: GLMA Annual Conference: "Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD," Invited Presentation
10. October 2014: New York Transgender Health Conference: "Mental Health Assessment in Gender Variant Children," Invited Presentation.
11. November, 2014: Gender Spectrum East: "Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations."
12. October 2015: "Gender Dysphoria and Complex Psychiatric Co-Morbidity," LGBT Health Conference, Invited Speaker
13. October 2015: "Transgender Health Disparities: Challenges and Opportunities," Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: "Autism and Gender Variance," Gender Conference East, Invited Speaker
15. February 2016: "Working with Gender Variant Youth," New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: "Working with Gender Variant Youth," National Council for Behavioral Health Annual Meeting, Invited Speaker
17. March 2016: "Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation," Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: "Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: "LGBTQ Youth Psychiatric Care," Midwest LGBTQ Health Symposim
20. October, 2016: "Gender Fluidity and Gender Identity Development," NYU Health Disparities Conference.
21. February, 2017: "Best Practices in Transgender Mental Health," Maimonides Grand Rounds
22. March, 2017: "Transgender Health: Challenges and Opportunities," Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: "Autism and Gender Dysphoria," Grand Rounds, NYU Department of Neurology.
24. November 2017: "Consent and Assent in Transgender Adolescents," Gender Conference East.

25. November 2017: "Transgender Mental Health: Challenges and Opportunities," Grand Rounds, Lenox Hill Hospital.
26. April 2018: "Gender Trajectories in Childhood and Adolescent Development and Identity," Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: "Social and Psychological Challenges of Gender Diverse Youth," Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: "Best Practices in Transgender Mental Health," Grand Rounds, Rush Department of Psychiatry.
29. February 2020: "The Overlap of Autism and Gender Dysphoria," Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: "Gender Dysphoria and Autism," Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: "Gender Diversity and Autism," Grand Rounds, Kaiser Permanente Department of Pediatrics
32. October 2021: Gender Dysphoria and Autism," Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: "Gender and Sexuality in Childhood and Adolescence," Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: "Supporting Transgender Students in School," NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: "LGBT Health," Presentation for Neuropsychology Department
4. August 2013: "Chronic Fatigue Syndrome: Etiology, Diagnosis and Management," invited presentation.
5. September 2013: Panelist, "LGBTQ Inclusive Sex Education."
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert
7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/
8. February 2016: "Best Practices in Transgender Mental Health," APA District Branch Meeting, Invited Speaker.
9. May 2016: "Best Practices in Transgender Mental Health," Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: "Transgender Youth," Union Square West
11. November 2017: "Understanding Gender: Raising Open, Accepting and Diverse Children," Heard in Rye, Conversations in Parenting.
12. January 2018: "The Emotional Life of Boys," Saint David's School Panel, Invited Speaker
13. June 2018: "Supporting Youth Engaged in Gender Affirming Care," NYU Child Study Center Workshop.
14. October 2018: "Medicine in Transition: Advances in Transgender Mental Health," NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: "Understanding Gender Fluidity in Kids," NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Selected Mentoring of Graduate Students, Residents, Post-Doctoral Fellows

2013-2014	Rebecca Hopkinson, Adult Psychiatry Resident, Provided clinical supervision for one year and training in transgender mental health. Dr. Hopkinson works as at Attending Child Psychiatrist at Seattle Children's and works with transgender youth
2013-2014	Sara Weekly, Chief Child and Adolescent Psychiatry Resident. Provided clinical supervision. Dr. Weekly is now an attending physician at Bay Area Children's Association in Oakland, California.
2013-present	Elizabeth Glaeser, Undergraduate Student. Provided research and administrative supervision. Elizabeth is now a PhD candidate in Psychology at Columbia and the director of research at the Gender and Family Project
2014-2015	Laura Erickson Schroth, Adult Psychiatry Resident. Provided clinical supervision for one year and training in transgender mental health. Dr. Erickson Schroth is the editor of Trans Bodies, Trans Selves, and Attending Psychiatrist at the Hetrick Martin Institute
2015-2016	Brandon Ito, Child Psychiatry Fellow, Provided Clinical Supervision. Dr. Ito is now an Attending Child and Adolescent Psychiatrist at UCLA.
2015-2017	Howard Huang, Undergraduate Student. Provided research supervision. Howard is now a PhD candidate in psychology at Boston College, pursuing work in gender and sexuality with published peer-reviewed literature.
2016-2019	Samantha Busa, PsyD, Post-Doctoral Fellow. Provide clinical supervision in transgender helath. Dr. Busa joined the NYU Gender and Sexuality Service as faculty in 2017.
2016-2019	Lara Brodsinzky, PhD, Attending Psychologist. Provide clinical supervision in transgender health. Dr. Brodsinzky is an Attending Psychologist on the NYU Pediatric Consultation Liaison Service.
2016-2019	Jeremy Wernick, MSW. Provide clinical and administrative supervision.
2017-2019	Serena Chang, Child Psychiatry Fellow; provide clinical and research supervision.

Major Research Interests

Gender and Sexual Identity Development
Member, Research Consortium for Gender Identity Development
Delirium: Assessment, Treatment and Management
Suicide Prevention

Research Studies

Study Title	IRB Study#	Dates
Suicide Attempts Identified in a Children's Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children's Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present
Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19

Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19
Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

Grant Funding:
Zero Suicide Initiative, PI Aron Janssen, M.D.
Awarded by Cardinal Health Foundation, 9/2020
Total amount: $100,000

Direct income for the department generated by teaching Sex Matters: Identity, Behavior and Development for the Child and Adolescent Mental Health Studies (CAMS) undergraduate program at NYU:

Time Frame	Income
2011 - 2016	$1,968,950

Selected Media Appearances:

Guest Expert on Gender Identity on Anderson, "When Your Husband Becomes Your Wife," Air Date February 8th, 2012
Guest Host, NYU About Our Kids on Sirius XM, 2011
NYU Doctor Radio: LGBT Health, September 2013
NYU Doctor Radio: LGBT Kids, November 2013
NYU Doctor Radio: LGBT Health, July 2014
NYU Doctor Radio: Gender Variance in Childhood, December 2014
BBC Two: Transgender Youth, April 2015
NYU Doctor Radio: Transgender Youth, June 2015
Fox-5 News: Trump's proposed military ban and Transgender Youth, July, 2017
Healthline.com: Mental Health Experts Call President's Tweets 'Devastating' for Trans Teens, July, 2017
Huffington Post: What the Military Ban Says to Our Transgender Youth: August, 2017
Metro: How to talk to your transgender kid about Trump, August 2017
NYU Doctor Radio: Transgender Youth, August 2017